		AND HUMAN SERVICES		PRINTED: 09/09/2010 FORM APPROVED				
CENTE	RS FOR MEDICARI	E & MEDICAID SERVICES			OMB NO. 0938-0391			
	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		185160	B, WING _	····	C 08/26/2010			
NAME OF P	PROVIDER OR SUPPLIER		STE	REET ADDRESS, CITY, STATE, ZIP CODE	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2			
LEXING	TON COUNTRY PLAC	EE	7	00 MASON HEADLEY ROAD LEXINGTON, KY 40504	ť			
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F 000	INITIAL COMMEN	TS	F 000					
F 241 SS≖D	conducted 08/24/1 Safety Code Surve Deficiencies were of and Severity of an substantiated with KY00015214 was of deficiencies cited, unsubstantiated wit 483.15(a) DIGNITY INDIVIDUALITY The facility must premanner and in an elenhances each residul recognition of healths.	bbreviated Survey was 0 through 08/26/10, and a Life by was conducted 08/25/10. cited with the highest Scope "E". ARO #KY00014847 was no deficiencies cited. ARO unsubstantiated with no ARO KY00014846 was th deficiencies cited. "AND RESPECT OF comote care for residents in a environment that maintains or cited to the cited of the	F 241	F 241 This Plan of Correction constitute facility's written allegation of comfor the deficiencies cited. However of this Plan of Correction in not at that a deficiency exists or that one correctly. This Plan of Correction to meet requirements established by and federal law.	e our apliance ar, submission a admission awas cited is submitted			
·	determined the factorized in a mann resident's dignity. (service revealed two standing while feed room.	lon and interview it was ility falled to ensure care was ler which maintained each Observation during meal to (2) staff members were ling realdents in the dining		It is the policy of Five Star Quality (Lexington Country Place) to prove services that meet professional state quality per state and federal regular (see attachment). 1. What corrective actions were	vide or arrange indards of ations taken for those			
,	The findings include			residents identified as having by the alleged deficient practi				
	08/24/10 at 12:30 F Assistant (CNA) #1 hand and feeding a Further observation standing while feed Interview with CNA	#1 on 08/24/10 at 12:40 PM		The residents at the Greenbrai were exposed to the deficient promoting care in an environt maintains and enhances each and respect. The CNAs were by the nurse manager and a chor sitting.	practice of nent that resident's dignity instructed promptly			
	Indela	CUONO RA	00	DDV.	9-17-10			
DUI Ge Cafa nua	ida provide sufficient pro date of survey whether o g the date these docume	rtection to the patients. (See instruction	a.) Except for	on may be excused from correcting provi nursing homes, the findings stated above nes, the above lindings and plans of correction I	e are disciossbie 90 dave			

FORM CMS-2567(02-99) Previous Versions Obsolate

If continuation sheet Page 1 of 21

meeting. Compliance and further monitoring

PRINTED: 09/09/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY (X1) PROVIDER/8UPPLIER/OLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEPICIENCIES **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING C B. WING 185160 08/26/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON COUNTRY PLACE **LEXINGTON, KY 40504** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) (D PREFIX (X6) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) F 241 Continued From page 1 F 241 What actions will be taken to identify other residents who may be affected by the alleged revealed the aide was a new employee and was still in orientation. CNA #1 stated the facility had deficient practice? provided training related to feeding the residents, but the aide did not remember anything specific All residents have the potential to be affected about standing and feeding. by the alleged deficient practice; therefore the facility will implement the corrective actions Interview with the Unit Manager (UM) on 08/24/10 discussed in #3 below. The Director of Nursing at 12:50 PM revealed she had seen the two (2) and social services made observation rounds and aldes standing over the residents while feeding. completed ten (10) resident interviews on She confirmed CNA #1 was "still learning" and 8/31/10 and 9/2/10. CNA #11 was from an outside agency. The UM provided a chair to the aide during the course of 3. What measures will be put into place or what the meal. Continued interview revealed staff systemic changes will be made to ensure that should have been sitting down to feed the the alleged deficient practice will not reoccur? residents. F 279 F 279 483.20(d), 483.20(k)(1) DEVELOP Unit Managers were in-serviced on August 26th **COMPREHENSIVE CARE PLANS** SS≂D By the Director of Nursing and all Nursing staff have mandatory in-services scheduled for September 17th, 18th, and 23rd to be conducted A facility must use the results of the assessment to develop, review and revise the resident's by the Director of Nursing related to standing comprehensive plan of care. while feeding, providing care with dignity, and promoting a respectful environment. All new The facility must develop a comprehensive care hires will receive resident dignity and respectful plan for each resident that includes measurable environment training by the staff development objectives and timetables to meet a resident's nurse during the orientation process. medical, nursing, and mental and psychosocial 4. How will the facility monitor its performance needs that are identified in the comprehensive to make sure solutions are sustained? assessment. The care plan must describe the services that are Unit nurse mangers or designee will monitor the to be furnished to attain or maintain the resident's resident dining areas during breakfast and lunch highest practicable physical, mental, and during the weekdays and the nurse house supervisor psychosocial well-being as required under or designee will monitor the dining areas during §483.25; and any services that would otherwise suppor for the weekdays and during the meal times be required under §483.25 but are not provided on the weekends. Unit mangers, house supervisors, due to the resident's exercise of rights under or designee will monitor care delivery for dignity §483.10, including the right to refuse treatment and providing a respectful environment (examples under §483.10(b)(4). include by not limited to providing privacy, knocking when entering, addresses by proper names, providing matching clothing, etc) by Event ID: CHP111 Facil FORM CM9-2567(02-99) Previous Versions Obsolète observation of care delivery by monitoring two (2) nursing staff members every shift daily for two (2) weeks, then every shift weekly for six (6)weeks, and then every shift monthly for three (3) months. Immediate staff education will be conducted if indicated. Monitoring tools will be reviewed during the facility morning interdisciplinary team meeting. In order to maintain ongoing compliance, concerns will be reviewed in the weekly "Standards of Care"

(XE) COMPLETION

DATE

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PRINTED: 09/09/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/BUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 185160 08/26/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE. **700 MASON HEADLEY ROAD** LEXINGTON COUNTRY PLACE **LEXINGTON, KY 40504** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) IÓ PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 279 Continued From page 2 F 279 Completion Date 10/4/10 This REQUIREMENT is not met as evidenced by: F 279 Based on observation, interview and record review it was determined the facility failed to ensure Comprehensive Plans of Care were This Plan of Correction constitutes our facility's written allegation of compliance developed to meet the residents' medical and for the deficiencies cited. However, submission nursing needs for two (2) of twelve (12) sampled residents (Resident #3 and #2). of this Plan of Correction in not an admission that a deficiency exists or that one was cited The findings include: correctly. This Plan of Correction is submitted to meet requirements established by the state 1. Record review revealed Resident #3 had and federal law. multiple admissions, the most recent being 07/29/10. Review of the Physician's Admission It is the policy of Five Star Quality Care Orders and the Resident Admission Record (Lexington Country Place) to provide or arrange revealed the resident had an allergy to Levaquin services that meet professional standards of (an antibiotic). Review of the Care Plan dated, quality per state and federal regulations 07/14/10, prior to the most recent hospitalization, (see attachment). revealed Resident #3 was allergic to Synthroid, a thyrold hormone replacement drug. What corrective actions were taken for those residents identified as having been affected Further review of the Physician's Orders and the by the alleged deficient practice? Medication Administration Record revealed Resident #3 was receiving Synthroid, fifty (50) Resident #3's clinical record and comprehensive micrograms, daily. care plan was corrected with the accurate drug allergy information on August 26, 2010. Interview with the Minimum Data Set (MDS) Resident #2's clinical record and comprehensive Coordinator on 08/26/10 at 2:30 PM revealed she care plan was corrected with the accurate could not say why she noted Synthroid as an safety alarm device to the wheelchair on allergy on the Care Plan. She stated she may August 24, 2010. have confused the drug Levaquin with the generic term for Synthroid (Levothyroxine). What actions will be taken to identify other residents who may be affected by the alleged Interview with the Director of Nursing (DON) on deficient practice?

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08/26/10 at 3:00 PM revealed she had checked with the resident's physician and there was no

resident had exhibited no adverse reaction to

documented allergy to Synthroid. Additionally, the

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All residents have the potential to be affected by the alleged deficient practice; therefore the facility will implement the corrective actions discussed in #3 below. Medical records audited five (5) active resident charts from each unit to compare physician orders, comprehensive care plan, and the nursing assistant care plan for accuracy by 9/23/10. Medical records completed the allergy audit on all resident charts for accuracy by 9/17/10, see #3 for specific audit.

		AND HUMAN SERVICES					FORM	: 09/09/2010 APPROVED : 0938-0391
ATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDENSUPPLIET/CLIA IDENTIFICATION NUMBER:	(X2) M			CONSTRUCTION	(X0) DATE SURVEY COMPLETED	
	i	185160	B. WI					C 6/2010
	ROVIDER OR SUPPLIER ON COUNTRY PLAC	SE		70	00 M	ADDRESS, CITY, STATE, ZIP CODE ASON HEADLEY ROAD NGTON, KY 40504		• •
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG			PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP OFFICIENCY)	OULD BE	(X6) COMPLETION DATE
COVER TO SERVICE TO SE	daily administration of the drug. The resident was, however, allergic to Levaquin. 2. Review of Resident #2's clinical record revealed diagnoses which included Dementia and a History of a Cerebrovascular Accident (CVA). Review of the Admission Minimum Data Set (MDS) Assessment dated 08/08/10 revealed the facility assessed the resident as having both short and long term memory loss, and as requiring total assistance for transfers. Review of the Resident Assessment Protocol Surimary (RAPS), dated 08/06/10 revealed the resident was non-ambulatory and relied upon a wheelchair and staff assistance for locomotive needs. Review of the Physician's Orders dated 08/10 revealed orders for a pressure alarm to the wheelchair to alert staff of unassisted transfers. Observation of Resident #2 on 08/24/10 at 11:50 AM revealed the resident was in a wheelchair in the day room; however, there was no alarm noted on the wheelchair. Observation of Resident #2 on 08/24/10 at 12:30 PM revealed the resident was in the dining room being fed by staff and there was no alarm noted on the wheelchair. Further observation of Resident #2 on 08/25/10 at 11:00 AM revealed the resident sitting in a wheelchair in the dayroom and there was no chair alarm on the wheelchair.			279	3.	What measures will be put in systemic changes will be mad the alleged deficient practice	le to ensure	that
						Safety device audits by the movers completed on all resider 17th with a comparison to the the comprehensive care plan, the treatment record, clinical safety assessment. All Nursing staff have mand scheduled for September 17	nts by Septe physician's the CNA or record, and	mber orders, are plan, resident
						to be conducted by the Dire related to safety device order monitoring, and care plans.		
						Medical records completed a for accurate resident allergy is comparison to the condition admission assessment (POS) on September 10 th and 17 th we corrections made if indicated was added to the resident admission. The medical record consultant monthly report and present to team consisting of administration of allergy infuscheduled meetings for September 10 th and 10 th we resident safety devices, and the consisting of administration of allergy infuscheduled meetings for September 10 th and 10 th	information alert sheet, for and the car with immedia. This allerguission audical records in as and reading will compose the monthlation, medication, medication on ember 17th, all be in-serv	with ace sheet, e plan ate ty audit at sheet ext missions. elete a ly CQI al accurate the 18th, & 23td
	dated 08/24/10 re	vealed the resident was at risk				the orientation process.	4 6.41	rision.

for falls because of dependency on others for

interventions listed for fall prevention; however,

daily care needs. There were several

The MDS nurse and care plan team (dietitian,

therapy, social services, nursing, activities, and

FAX NO. 859 276 2751 SEP-28-2010 TUE 12:25 PM LEXINGTON COUNTRY PLACE PRINTED: 09/09/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C B. WING 185180 08/26/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CMY, STATE, ZIP CODE 700 MASON HEADLEY ROAD **LEXINGTON COUNTRY PLACE** LEXINGTON, KY 40604 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (XG) COMPLETION (X4) ID EACH CORRECTIVE ACTION SHOULD BE PREFIX IEACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CAOSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 279 Continued From page 4 F 279 How will the facility monitor its performance the alarm to the wheelchair was not noted as an to make sure solutions are sustained? intervention. In order to monitor ongoing compliance, unit Interview on 08/24/10 with the MDS Coordinator managers will maintain a safety device log with revealed the Interim Care Plan was written on daily undates according to changes with physician 07/24/10, on the resident's day of re-admission. orders and resident assessment changes. The log will She stated the Intervention for the chair alarm will be reviewed at the weekly "Standards of Care" was on the Interim Care Plan; however, she had

Review of the facility's, "Process for Plan of Care Development and Communication" Policy, revealed the admitting nurse would develop and initiate a written plan of care for the resident within 24 hours of admission or re-admission to include Physician's Orders and additional assessments and interventions as deemed appropriate. After the Initial Resident Assessment Instrument was completed, the Comprehensive Care Plan would be further developed and communicated to staff. The Care Plan was to be reviewed at re-admission, with a change in condition, and no less than every ninety (90) days.

falled to ensure the intervention was carried over

to the Comprehensive Plan of Care.

F 281 SS=D 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONA'L STANDARDS

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review it was determined the facility falled to ensure Physician's Orders were followed for one (1) of twelve (12) sampled residents (Resident #2).

meetings. The safety device orders will be placed on the resident treatment record with a nurse check documented every shift for compliance that the device is intact and functioning appropriately. The unit managers will monitor the treatment records for compliance in nurse documentation weekly and report to "Standards of Care". Compliance will be reported by the Director of Nursing during the monthly quality assurance (COI) meeting. These monitoring audits of safety devices and resident allergies will be ongoing tools and any findings will be addressed and any corrective actions will be initiated at that time. Medical records will audit two (2) charts from each unit monthly for compliance and accuracy in developing and updating the comprehensive care plans and report findings to the DON or MDS nurse promptly if a correction is needed and to the monthly CQI meetings.

Completion Date 10/4/10

F 281

and federal law.

F 281

This Plan of Correction constitutes our facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction in not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state

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It is the policy of Five Star Quality Care (Lexington Country Place) to provide or arrange services that meet professional standards of quality per state and federal regulations (see attachment).

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She stated the aides were to refer to the "Nursing

Assistants Report Sheet" when caring for the

resident was to have a chair alarm. Further

residents. She reviewed the Report Sheet and

stated the intervention for a chair alarm was on

the Report Sheet; however, she was unaware the

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all new physician orders in the next scheduled Fadility if morning stand up meeting to ensure transcription of 21 of order to the treatment record or medication record, update the CAN care plan, ensure implementation of the order, and update the comprehensive care plan. All physician orders will be placed on the twenty-four hour report for seventy-two hours to ensure communication between shifts with unit managers to monitor.

All Nursing staff have mandatory in-services

scheduled for September 17th, 18th, and 23rd

to be conducted by the Director of Nursing

monitoring, and care plans.

related to safety device orders, implementation,

Unit managers and the MDS nurses will review

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM A OMB NO.	\PPROVED <u>0938-0391</u>
TEMENT	S FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		LE CONSTRUCTION	(X3) DATE SU COMPLET	RVEY IED
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•	ROVIDER OR SUPPLIER ON COUNTRY PLAC	E		70	BET ADDRESS, CITY, STATE, ZIP CODE TO MASON HEADLEY ROAD EXINGTON, KY 40504		•
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F 323 \$8=E	Report Sheet, and question about a re Resident #2 in the resident did not ha and also stated the alarm on the whee was assigned to the Interview on 08/25. Manager/Licensed revealed she was a Physician's Ordereviewed the mediwas a current Physician and third a ensure safety devision a Safety Devision a Safety Devision a Safety Devision Associated The facility must environment remains is possible; and	she did not roulinely check the only checked it if she had a seldent. CNA #5 observed wheelchair and confirmed the ve an alarm on the wheelchair, resident did not have an ichair on 08/24/10, when she resident. /10 at 11:10 AM with the Unit Practical Nurse (LPN) #7, not sure if the resident etill had in for a chair alarm. LPN #7 cal record, and stated there sician's Order for an alarm to unther interview revealed the shift nurses were to check to cee were in place daily and ces Record each day, however, red the Safety Devices Record OF ACCIDENT RVISION/DEVICES Insure that the resident hazards it each resident receives sion and assistance devices to		281 4.	Unit managers to monitor TARs in documentation and compliance the are in use every shift and night she to audit safety devices every night and working function. The MDS nurse and care plan teat The resident charts scheduled for plan meetings for the completion by auditing the physician orders, MARs and TARs, updates the couplan, and the CNA care plan for a All nursing new hires will be insafety devices during the orientate. How will the facility monitor its to make sure solutions are sustain in order to monitor ongoing commanagers will maintain a safety daily updates according to chang orders and resident assessment of	at safety devices and courners. performance in process. performance in process.	care cont coare n orders, n to coare esident ician log will Care" ty d
	by: Based on observa review it was dete ensure adequate	ENT is not met as evidenced ation, interview and record ormined the facility failed to supervision and assistive t accidents for one (1) of twelve			any findings will be addressed an corrective actions will be initiate. Medical records will audit two (Each unit monthly for compliant of following physician orders and to the DON or MDS nurse promis needed and monthly to the CC continue as determined by the C	nd any ad at that tim 2) charts from ce and accura d report find ptly if a corr 2) team and	e. m acy lings rection

PRINTED: 09/09/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A, BUILDING C B. WING 185160 08/26/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD **LEXINGTON COUNTRY PLACE LEXINGTON, KY 40504** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X6) COMPLETION (X4) (D (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PACFIX REGULATORY OR LEC IDENTIFYING INFORMATION) CAOSS-REFERENCED TO THE APPROPRIATE TAG DAT **DEFICIENCY** F 323 F 323 Continued From page 7 F 323 (12) sampled residents (Resident #2). Also, the facility failed to provide a safe environment This Plan of Correction constitutes our related to items left unattained which could pose facility's written allegation of compliance a danger to the residents. for the deficiencies cited. However, submission of this Plan of Correction in not an admission The findings include: that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted 1. During the initial tour on 08/24/10 at 9:40 AM, to meet requirements established by the state observation revealed the door to a housekeeping and federal law. closet on the 300 Unit was unlocked, with no housekeeping staff within sight of the door. It is the policy of Five Star Quality Care Inside the housekeeping closet were hazardous (Lexington Country Place) to provide or arrange chemicals which included Oasis 259 Glass Force, services that meet professional standards of and TB Disinfectant and Deodorizer. Review of quality per state and federal regulations the Material Safety Data Sheet (MSDS) for Oasis (see attachment). 259 Glass Force revealed it may be latal if swallowed. The MSDS for TB Disinfectant and What corrective actions were taken for those Deodorizer revealed it was harmful if absorbed residents identified as having been affected through the skin, swallowed or inhaled. by the alleged deficient practice? Interview with Housekeeper #1 on 08/24/10 at The housekeeping closet door on unit 3 containing 9:46 AM, who was around the corner cleaning an hazardous chemicals was locked on August 24th unsampled resident's room, revealed and the housekeeping staff was instructed that day housekeeping staff were to keep the on safety regulations related to locked chemicals. housekeeping closets locked. She stated, she was the last person to get supplies out of the unlocked housekeeping closet. Further interview Resident #2's clinical record and comprehensive care plan was corrected with the accurate revealed, after securing items from the safety alarm device applied to the wheelchair on housekeeping closet, the breakfast trolley was in the way preventing her from securing the door. August 24, 2010. Interview with the Housekeeping Supervisor on What actions will be taken to identify other residents who may be affected by the alleged 08/25/10 at 10:25 AM revealed housekeeping doors were to be locked when not in use to deficient practice?

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being in the way.

ensure resident safety. Further interview revealed, sometimes the housekeeping door on

the 300 Hall was unlocked due to the food trolley

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Facility (D

All mobile residents have the potential to be affected by the alleged deficient practice related to locked chemicals and all residents with orders for safety alarm devices have the potential to be affected by the alleged deficient practice; therefore the facility will implement the corrective actions discussed in #3 below.

The DON and social services made observation rounds viewing locked housekeeping carts, closets, and environmental safety and interviewed five (5) employees and ten (10) residents on 8/31/10 and 9/2/10.

		& MEDICAID SERVICES				OMB NO.	0938-0391
ATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		LE CONSTRUCTION	(X9) DATE SURVEY COMPLETED C	
	٠	186160	0. WII	VG			3/2010
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F 323	undated, revealed a facility had been as wandering. Eight (residents resided or Interview with Regibeen on duty on the PM, revealed two (were at risk for was safety awareness. 2. Review of Resirevealed diagnose: Dementia and a HI Accident (CVA). Resident as having skills for decision massistance for tranambulate. Review of the Res Summary (RAPS), resident was non-wheelchair and staneeds. Review of the Fall: 07/24/10 revealed risk for falls related physical abilities a bowel and bladder one (1) to two (2) required the use of Review of the Physical was not the Physical was not the Physical abilities a bowel and bladder one (1) to two (2) required the use of Review of the Physical was not the	dering/Elopement Risk List, seventeen (17) residents in the seesed to be at risk for 8) of the seventeen (17) in the 300 Unit. stered Nurse (RN) #2 who had a 300 Unit on 08/26/10 at 3:25 2) residents on the 300 Unit indering and had decreased dent #2's clinical record a which included Advanced story of Cerebrovascular eview of the Admission (MDS) Assessment dated the facility assessed the severe impairment in cognitive naking, as requiring total sfers, and as being unable to deted 08/06/10 revealed the ambulatory, and utilized a lift assistance for locomotive and limitations, incontinence of and required the assistance of people for transfers and/or	F	323	3. What measures will be put in systemic changes will be mathe alleged deficient practice. Housekeeping staff were in-served 1st and 16th related to safety meal locked storage at all times of all chemicals if not in use by the statemicals if not in use by the statemical statement process. Safety device audits by the nurse were completed on all residents 17th with a comparison to the phase the comprehensive care plan, that the treatment record (TAR), climates after the safety assessment. All Nursing staff have mandator scheduled for September 17th, I to be conducted by the Director related to safety device orders, monitoring, and care plans. Unit managers and the MDS nursell new physician orders in the remorning stand up meeting to ensor of order to the treatment record, care plan, ensure implementation and update the comprehensive of Unit managers to monitor TARs documentation and compliance are in use every shift and night sto audit safety devices every night and working function. Safety device training will be connew nursing hires during the ori	de to ensure will not recoviced no Augustres regard hazardous aff and all new hire e unit manage by Septemb dysician's one CNA care nical record, and 23 rd rof Nursing implementate reses will review schedule sure transcrippdate the Cn of the deviare plan. It for nursing that safety desired in the corplacer onducted with the corplacer onducted with a safety desired in the corplacer onducted with the corplacer onducted with the corplacer onducted with the corplacer onducted with the corplacer of the corplacer onducted with the corplacer of the c	that ccur? just ing ust ling s gers er ders, plan, and es ion, iew ed prion ENA ice, evices nurse nent h all

PRINTED: 09/09/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION . IDENTIFICATION NUMBER: A. BUILDING C B. WING 185160 08/28/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON COUNTRY PLACE **LEXINGTON, KY 40504** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (XA) CÓMPLETION (X4) ID PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 323 F 323 Continued From page 9 How will the facility monitor its performance to make sure solutions are sustained? wheelchair to alert staff of unassisted transfers. Observation of Resident #2 on 08/24/10 at 11:50 In order to monitor ongoing compliance, the Housekeeping manager or designee will conduct AM and 12:30 PM, and 08/25/10 at 11:00 AM daily monitoring for two (2) weeks, then weekly for revealed the resident was sitting in a wheelchair; however, there was no chair alarm observed on six (6) weeks, and then monthly for three (3) months and implement corrective actions and staff training the wheelchair. if indicated. Housekeeping Manager will report to Review of the Comprehensive Plan of Care dated the monthly CQI meeting with ongoing compliance. 08/24/10 revealed the resident was at risk for falls because of dependency on others for daily care In order to monitor ongoing compliance, unit needs. There were several interventions listed for managers will maintain a safety device log with fall prevention; however, an alarm to the daily updates according to changes with physician wheelchair was not listed as an intervention. orders and resident assessment changes. The log will will be reviewed at the weekly "Standards of Care" Interview on 08/24/10 at 10:45 AM with the MDS Coordinator revealed the Interim Care Plan was The unit managers will monitor the treatment written on 07/24/10 which was the resident's day records for compliance in nurse documentation of re-admission. She stated the intervention for weekly and report to "Standards of Care". the chair alarm was on the Interim Care Plan; Compliance will be reported by the however, it had not been carried over to the Director of Nursing during the monthly quality Comprehensive Plan of Care. assurance (CQI) meeting. Interview on 08/25/10 at 11:00 AM with Certified These monitoring audits of safety devices Nursing Assistant (CNA) #5, revealed she was will be ongoing tools and assigned to the resident on 08/24/10 and any findings will be addressed and any 08/25/10. She stated the aides were to refer to corrective actions will be initiated at that time. the "Nursing Assistants Report Sheet" which they carried in their pockets when caring for the **Completion Date** residents. CNA #5 reviewed the Report Sheet 10/4/10 and stated the resident was to have a chair alarm. Further interview, revealed she did not routinely check the Report Sheet when caring for the residents, and only checked it if she had a question. CNA #5 confirmed the resident did not

have an alarm on the wheelchair, and also stated

the resident did not have an alarm on the wheelchair on 08/24/10 while she was assigned

PRINTED: 09/09/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING Ć B. WING 185160 08/26/2010 NAME OF PROVIDER OR BUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD **LEXINGTON COUNTRY PLACE LEXINGTON, KY 40504** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX ID (X6) COMPLETION (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 323 F 323 Continued From page 10 Interview on 08/25/10 at 11:10 AM with the Unit Manager/Licensed Practical Nurse (LPN) #7, revealed she was unsure if the resident still had a Physician's Order for a chair alarm. The Unit Manager reviewed the medical record, and stated F 328 there was a current Physician's Order for an alarm to the wheelchair. Continued interview, This Plan of Correction constitutes our revealed the second and third shift nurses were to facility's written allegation of compliance check to ensure safety devices were in place daily for the deficiencies cited. However, submission and sign a Safety Devices Record each day to of this Plan of Correction in not an admission turn in: however, she had not received the Safety that a deficiency exists or that one was cited Devices Record for 08/24/10. correctly. This Plan of Correction is submitted to meet requirements established by the state Interview on 08/26/10 at 9:30 AM with the Director and federal law. of Nursing (DON) revealed staff needed education related to reading the Nursing Assistant It is the policy of Five Star Quality Care Report Sheets for safety devices. She further (Lexington Country Place) to provide or arrange stated the night shift staff were to ensure safety services that meet professional standards of devices were in place and operating. 483.25(k) TREATMENT/CARE FOR SPECIAL quality and proper treatment and care of special F 328 F 328 services per state and federal regulations **NEEDS** 88=D (see attachment). The facility must ensure that residents receive 1. What corrective actions were taken for those proper treatment and care for the following apecial services: residents identified as having been affected Injections; by the alleged deficient practice? Parenteral and enteral fluids: Colostomy, ureterostomy, or ileostomy care; The tube feeding bottle and tubing was Tracheostomy care; disposed of immediately on resident #2 Tracheal suctioning: by the unit manager when she was notified the Respiratory care; the tube feeding was not labeled with the Foot care; and date and time the bottle was opened and hung, Prostheses. resident's name, the tube feeding rate, and the nurse's initials who hung it,

FORM CMS-2567(02-99) Previous Vereigne Obsolete

This REQUIREMENT is not met as evidenced

Based on observation, interview and record

Event ID; CHP111

Facility ID:

All residents with enteral nutrition or tube feeding methods have the potential to be affected by the alleged deficient practice; therefore the facility will implement the corrective actions discussed in #3 below.

However, Resident #2 is the only resident in the facility with tube feedings.

What actions will be taken to identify other residents who may be affected by the alleged

deficient practice?

SEP-28-2010 TUE 12:27 PM LEXINGTON COUNTRY PLACE FAX NO. 859 276 2751 PRINTED: 09/09/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** OMB NO. 0938-0391 : CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C 8. WING 185160 08/26/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD **LEXINGTON COUNTRY PLACE LEXINGTON, KY 40504** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX GACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) The facility has no residents with tracheostomy F 328 F 328 Continued From page 11 needs or dialysis needs. All residents charts with review, it was determined the facility falled to respiratory needs were audited by the unit ensure proper treatment and care for tube managers for accuracy by 9/13/10. Foley catheters feeding services for one (1) of twelve (12) are audited weekly by the unit managers for accuracy sampled residents (Resident #2). and reported to the weekly "Standards of Care" meetings. The facility The findings include: has one resident with a prosthetic limb and one resident with a ostomy appliance and these 1. Review of Resident #2's clinical record charts were audited on 9/27/10 by the MDS revealed diagnoses which included Dysphagla, nurse for accuracy. All resident charts will be and Status Post Gastrostomy Tube Placement. audited for special care needs by medical records by 9/30/10 for accuracy in physician orders, Review of the Physician's Orders dated 08/10 revealed orders for "2 Cal HN" (tube feeding) at transcription, comprehensive care plans, CNA fifty-five (55) millillers per hour, to run from 8:00 care plans, and supporting diagnosis. PM until 8:00 AM. Observation on 08/24/10 at 11:45 AM revealed a 3. What measures will be put into place or what bottle of "2 Cal HN" tube feeding hanging on a systemic changes will be made to ensure that tube feeding pump which was turned off. There the alleged deficient practice will not reoccur? was no indication on the tube feeding bottle of the resident's name, the date or time the bottle was Review of the "Enteral Nutrition Guidelines" opened and hung, or the tube feeding rate. and an addendum added to include accurate labeling of tube feeding bottles by nurses. Interview on 08/24/10 at 11:50 AM with the Unit Nursing staff in-services are scheduled for Manager, revealed the tube feeding was to run for September 17th, 18th, and 23rd for review of twelve hours and then the bottle and tubing were labeling tube feeding bottles accurately with to be discarded. She further stated, the nurse the resident's name, nurse's initials who hung who worked the previous shift should have written it, date and time the bottle was hung, and the the resident's name, date and time the tube tube feeding rate. DON will in service nursing feeding was hung, the tube feeding rate, and the staff on resident special care needs and nurse's initials on the tube feeding bottle when it compliance with resident assessment, appropriate was hung. Further interview revealed the nurse documentation, physician orders, diagnosis, and who worked the previous shift was not a regular care plans on 9/30/10 and 10/2/10. All new nurses will be trained on policy and labeling of tube

nurse on the unit and floated to all the units.

Review of the "Enteral Nutrition Guidelines" Policy revealed there were no instructions related to labeling the tube feeding bottle prior to delivery of tube feeding.

FORM CMS-2567(02-99) Previous Versione Obsolete

Event ID: CHP111

Fa

weekly scheduled care plans for accuracy in caring 21

feeding and special care needs during new hire

orientation. All physician orders will be placed

communication between shifts. MDS nurse and

care plan team with audit the resident charts at the

on the 24 hour report fro 72 hours to ensure

for resident with special care needs.

PRINTED: 09/09/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0<u>391</u> CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C 185160 08/26/2010 STREET ADDRESS, OITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 700 MASON HEADLEY ROAD LEXINGTON COUNTRY PLACE **LEXINGTON, KY 40504** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION (X4) ID PAEFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE REQULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 431 483.60(b), (d), (e) DRUG RECORDS, F 431 How will the facility monitor its performance LABELISTORE DRUGS & BIOLOGICALS SS=E to make sure solutions are sustained? The facility must employ or obtain the services of Unit nurse mangers or designee will monitor the a licensed pharmacist who establishes a system tube feedings daily for accurate labeling of the of records of receipt and disposition of all bottles and document on a log sheet to be reviewed controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug daily in morning stand up meetings for 4 weeks then records are in order and that an account of all at random weekly x8 weeks, then random monthly. Immediate staff education and corrective actions controlled drugs is maintained and periodically will be conducted if indicated during monitoring. reconciled. .In order to maintain ongoing compliance, concerns Drugs and biologicals used in the facility must be will be reviewed in the weekly "Standards of Care" labeled in accordance with currently accepted meeting. Compliance will be reported by the professional principles, and include the Director of Nursing during the monthly quality appropriate accessory and cautionary Assurance (CQI) meeting. instructions, and the expiration date when Medical records will audit two (2) charts from applicable. each unit monthly for compliance and accuracy in resident special care needs to ensure physician in accordance with State and Federal laws, the orders are followed, transcription, appropriate facility must store all drugs and biologicals in diagnosis, updates to the comprehensive care locked compartments under proper temperature plan, and CNA care plan updates. Medical records controls, and permit only authorized personnel to will report to DON or MDS nurse for correction have access to the keys. if indicated promptly, and to the monthly CQI meetings. The facility must provide separately locked, Completion Date permanently affixed compartments for storage of 10/4/10 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to F 431 abuse, except when the facility uses single unit package drug distribution systems in which the This Plan of Correction constitutes our quantity stored is minimal and a missing dose can facility's written allegation of compliance for the deficiencies cited. However, submission be readily detected.

FORM CMS-2567(02-89) Previous Versions Obsolete

by:

This REQUIREMENT is not met as evidenced

Based on observation, interview and record

Event ID: CHP111

It is the policy of Five Star Quality Care (Lexington Country Place) to provide or arrange services that meet professional standards of quality per state and federal regulations (see attachment).

of this Plan of Correction in not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted

to meet requirements established by the state

and federal law.

1. What corrective actions were taken for those residents identified as having been affected by the alleged deficient practice?

No specific residents were identified as having

		AND HUMAN SERVICES	-		•		APPROVED 0938-0391
ATEMENT	S FOH MEDICARE F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSYRUCTION	(X3) DATE 81 COMPLE	URVEY
	÷	185160	B. WIN				C 6/2010
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F 431	review it was deter ensure drugs and istored in accordan professional principathe Magnolia Unit is vials which were of addition, there were medication room. open tube of Triple not bagged, dated The findings included the finding included the findi	mined the facility falled to biologicals were labeled and ce with currently accepted bies. The medication room on refrigerator had expired insulingen and ready for use. In expired supplies in the Also, a treatment cart had an Antibiotic cintment which was or labeled. It: Magnolia Unit medication at 3:45 PM revealed a vial of ulin with an open date of all of Novolin R Insulin with an /10 in the medication dication room had expired luded; change trays in a cabinet with 10/09, 01/10, and 06/10, intravenous (IV) catheters with of 07/10, four (4) IV catheters date of 05/10, and a box of seters (3 cc) syringes with an	F.	431	residents who may be affect deficient practice? The expired supplies in the the insulins, and the ointmet of immediately when identically when identically the alleged deficient practice facility will implement the facility will implement the facility contract pharms medication rooms and carts no outdated medications or managers inspected and cle and treatment carts 9/3/10 a corrective action and staff of the facility contract pharms inspected the controlled memedication carts and the end on 8/24/10, 8/30/10, and 9/24/10, and 9/24/1	medication rent were disposited on Augustial to be affectice; therefor the corrective acist inspected on 8/30/10 as supplies. The aned the medication if in acist reviewed ications on the regency conticated. Into place or made to ensure the will not recondatory in-serior of Nursed medications and rector of Nursed Medications and	noms, sed st 24th coted re actions d all the not found counit ication ted any adicated d and the crol box plemented what a that occur?
	Nurse (RN) #2 rev	realed the insulin vials were only good for twenty-eight (28)			supplies, proper labeling o maintenance of medication		, and the

FORM CMS-2687(02-99) Provious Varsions Obsolete

for expiration dates.

days after opening. She further stated she was

medications and supplies in the medication room

Interview on 08/24/10 at 4:00 PM with the Unit

unsure who was responsible for checking

Event ID: CHP111

10/2/10.

of expired medications and supplies, proper medication labeling, and maintaining clean,

organized medication rooms, receiving, storage, medication orders, and disposing of medications appropriately during the new hire orientation process.

All new nurses will be in-serviced on disposal

The DON will in service nurses on the proper

receiving, storage, pharmacy response to

medications appropriately on 9/30/10 and

medication orders, and disposing of

4 of 21

		AND HUMAN SERVICES		·	FORM	09/09/2010 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MŲ A. BUIL	ULTIPLE CONSTRUCTION DING	(X3) DATE 8L COMPLE	IAVEY TED
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F 431	revealed she was checking for expire room. Interview on 08/26 of Nursing revealed medication rooms disorganized" and Supervisor to be in rooms. However, were responsible medications and strooms. Review of the facilisation of Supplies for Admit the charge nurse supplies relating to were clean and or pharmacist monitor conditions. Review of the facilisation Dates". Novolog 70/30 instruenty-eight (28) of Insulin should bafter opening. 2. Observation of 08/24/10 at 4:00 full. The ointmentiabeled. Upon dis Practical Nurse (LThe LPN stated, 1975).	Practical Nurse (LPN) #7, unsure who was responsible for ed items in the medication /10 at 9:30 AM with the Director d she was aware the were "cluttered and she had plans for the night shift in charge of the medication at that time, the Unit Managers for checking for expired supplies in the medication distering Medications", revealed on duty ensured equipment and of medication administration derly, and the consultant ored medication storage	F 4		Il conduct inspections, cart inspections, cart inspections for once a quarter if dings will be ry corrective action e. updated informatic iration Dates" for for medications. If all medication carts and come on September carts and come on September carts and come on September carts weekly with, 18th, and 23th. It it its performance sustained? Or medication room ent carts weekly wised and any correct e. The night shift (ble for cleaning are to report concerns to report to the monthly are to report concerns with the control of the monthly inspections at the control of th	ns on 'hese books or 1st g e synth tive od ly orns of Care'' y CQL orting orting othe lity oted, and eetings.
FORM CMS	 	ina Obsolete Event ID: CHP11	<u> </u>	Facility ID: 100527	If continua 10/4/1	

and reported weekly to the Don in the "Standards of Care" meetings. The DON or designee monitors the infection control program (ICP). The ICP consists of surveillance, data collection, detection, investigation, management, antibiotic review, isolation precautions, education, exposure

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 09/09/2010 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
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F 441 SS=D	should have been a 483.65 INFECTION SPREAD, LINENS The facility must es infection Control Program and infection Control Program under what is a should be applied to the facility must exprogram under what is a should be applied to it is a should be	no unlabeled medications stored on the treatment cart. N CONTROL, PREVENT stabilish and maintain an regram designed to provide a comfortable environment and development and transmission ection. of Program stabilish an infection Control ich it ontrols, and prevents infections procedures, such as isolation, to an individual resident; and cord of incidents and corrective infections. ead of infection stored of infection, the facility must the infection, the facility must the control program resident needs isolation to it of infection, the facility must the infection of infection infections in the infection of infection infections. It is the prohibit employees with a sease or infected skin lesions it with residents or their food, if infect resident contact for which indicated by accepted ice.	F	441	This Plan of Correction const facility's written allegation of for the deficiencies cited. How of this Plan of Correction in a that a deficiency exists or that correctly. This Plan of Correct to meet requirements establish and federal law. It is the policy of Five Star Q (Lexington Country Place) to services that meet professions quality per state and federal residents identified a by the alleged deficient been affected by the The KMA #2 and or in-serviced on August of hand washing, us infection control guidents who may be deficient practice? All residents have the by the alleged deficient practice? All residents have the facility will impediscussed in #3 below the DON reviewed Control logs for the Facility outbreaks of 10/1/10. Resident in	f compliance wever, submission t one was cited bettion is submitted hed by the state mality Care provide or arrar al standards of regulations ions were taken if as having been a ient practice? was identified a calleged deficien in the CNA #5 we ist 26, 2010 by the e of hand sanitize idelines. the taken to identify be affected by the he potential to be iont practice; the olement the corre ow. I the resident insi- past thirty days of infectious dise	for those ffected as having at practice. as he DON ter and for alleged energy actions and found asses on
DRM CMS-2	direct contact will t (3) The facility must hands after each of hand washing is in professional practic. (c) Linens Personnel must he transport linens so infection.	ransmit the disease. st require staff to wash their direct resident contact for which dicated by accepted ice. andle, store, process and as to prevent the spread of		Fe	residents who may be deficient practice? All residents have the by the alleged defice the facility will impediscussed in #3 below The DON reviewed Control logs for the Facility outbreaks of the control logs for the control logs for the control logs for the facility outbreaks of the control logs.	he affected by the he potential to be ient practice; the element the correct the resident inspections disconfictions are tractions are tractions are tractions are tractions are tractions are tractions are tractions.	e affect erefore ective a pection and for ases on thed, and

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CREMENTO CORRECTION CREMENT OF DEPTOIRMONNUMBER DENTIFICATION NUMBER DENTIFICATION			AND HUMAN SERVICES & MEDICAID SERVICES					APPROVED 0938-0391
This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain an infection Control Program designed to provide a safe, and sanitary environment to help prevent the development and transmission of disease and infection. The findings include: Review of the facility's, "Handwashing' Policy revealed handwashing was the most important component for preventing the spread of infection. The Policy further stated, handwashing should be performed when hands were visibly soiled, before and after resident contact, after contact with soiled or contaminated articles, such as a ratices that were contaminated articles, such as a ratices that were contaminated articles, such as a ratices that were contaminated with body fluids, and after removal of medical/surgical or utility gloves 1. Observation of the medication pacs on OB/25/10 at 8:30 AM revealed Kentucky Medication Assistant (KMA) #2 administered medicalions to unsainpied Resident #1, with a spoon and assisted the resident to opt not a cup.	TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	l' '		•	COMPLE	TED
LEXINGTON COUNTRY PLACE STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504 A LEXINGTON, KY 40504 LEXINGTON, KY 40504 LEXINGTON, KY 40504 A LEXINGTON, KY 40504 LEXINGTON, KY 40504 A LEXINGTON, KY 40504 LEXINGTON, KY 40504 A LEXINGTON, KY 4050			185160	B. WI	NG.	· · · · · · · · · · · · · · · · · · ·	1	*
F 441 Continued From page 16 F 441 Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record raview, it was determined the facility failed to maintain an Infection Control Program designed to provide a safe, and sanitary environment to help prevent the development and transmission of disease and infection. The findings include: Review of the facility's, "Handwashing" Policy revealed handwashing was the most important component for preventing the spread of infection. The Policy further stated, handwashing should be performed when hands were visibly soiled, before and after resident contact, after contact with soiled or contaminated articles, such as articles that were contaminated articles, such as articles that were contaminated with body fluids, and after removal of medical/surgical or utility gloves 1. Observation of the medication pacs on 08/25/10 at 8:30 AM revealed Kentucky Medications to unsampled Resident # 441 S What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice will not recom? All nursing staff was instructed on hand washing, use of hand sanitizer, review of the hand washing, use of hand sanitizer, review of the hand washing, use of hand sanitizer, infection control prevention and guidelines. All new hires will be in-serviced on hand washing, use of hand sanitizer, infection control prevention and guidelines. All new hires will be in-serviced on hand washing, use of hand sanitizer, infection control prevention and guidelines. All new hires will be in-serviced on hand washing, use of hand sanitizer, infection control prevention and guidelines. All new hires will be in-serviced on hand washing, use of hand sanitizer, infection control prevention, and guidelines during the theories of the facility of the orientation process. Education on infection control logs and new physician orders daily in the morning Stand up meetings. The DON or designee monitors the infection Con	'		E ,			700 MASON HEADLEY ROAD		
This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain an infection Control Program designed to provide a safe, and sanitary environment to help prevent the development and transmission of disease and infection. The findings include: Review of the facility's, "Handwashing" Policy revealed handwashing was the most important component for preventing the spread of infection. The Policy further stated, handwashing should be performed when hands were visibly soiled, before and after resident contact, after contact with soiled or contaminated with body fluids, and after removal of medical/surgical or utility gloves 1. Observation of the medication pacs on O8/25/10 at 8:30 AM revealed Kentucky Medication Assistant (KMA) #2 administered medications to unsampled Resident #1 with a spoon and assisted the resident to sip from a cup	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULI.	PAEF	ΉX	(EACH CORRECTIVE ACTION 8HO CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE
of water. KMA #2 then began to set up medications for the next resident. There was no evidence she washed or sanitized her hands after administering medication to unsampled Resident #1 and prior to beginning to set up medications for the next resident. Interview with KMA #2 on 08/25/10 at 8:35 AM revealed she usually sanitized her hands after administration of medication. Observation	F 441	This REQUIREMENT by: Based on observat review, it was determaintain an Infection to provide a safe, a help prevent the desort disease and infection to disease and infection to disease and infection to disease and infection of disease and infection for the findings included Review of the facility revealed handwast component for pretrained when he and after resident and assistent and assistent and assistent and assistent and assistent and prior to begin the next resident and prior to begin the next resident and assistent and prior to begin the next resident and assistent and prior to begin the next resident and assistent and prior to begin the next resident and assistent and prior to begin the next resident and assistent and prior to begin the next resident and assistent and prior to begin the next resident and assistent and prior to begin the next resident and assistent and prior to begin the next resident and assistent and prior to begin the next resident and assistent and prior to begin the next resident and prior to begin the n	NT is not met as evidenced ion, interview, and record rmined the facility failed to on Control Program designed and sanitary environment to evelopment and transmission action. It: Ity's, "Handwashing" Policy ming was the most important eventing the spread of infection. Stated, handwashing should be ands were visibly soiled, before contact, after contact with ated articles, such as articles and with body fluids, and after if surgical or utility gloves the medication pacs on M revealed Kentucky and (KMA) #2 administered sampled Resident #1, with a did the resident to sip from a cup then began to set up a next resident. There was no need or sanitized her hands after illustion to unsampled Resident ginning to set up medications int. A #2 on 08/25/10 at 8:35 AM ally sanitized her hands after	F	44	3. What measures will be put int systemic changes will be mad the alleged deficient practice of the alleged deficient practice of hand sanitizer, review of policy, and each employee perhand washing demonstration of 11th, by the staff development designees. All Nursing staff have mand scheduled for September 17th to be conducted by the Direct related to hand washing, use infection control prevention at All new hires will be in-service washing, use of hand sanitizer prevention, and guidelines dut the orientation process. Educ control guidelines will be con yearly by the staff developme. The nursing team monitors the logs and new physician orders morning Stand up meetings. The DON or designee monito Control program weekly during the staff development of the program weekly during the program w	e to ensure to will not record on hand worf the hand worformed a record September nurse and but atory in-services of Nursicof hand saniful guidelined on hand r, infection or ring the ation on infeducted twice at nurse or I e infection or sally in the ars the infect	chat cour? l vashing, vashing turn or 10 th er vices 3 ^{td} ng tizer, es. control ection control control

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C B. WING 185160 08/26/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **700 MASON HEADLEY ROAD LEXINGTON COUNTRY PLACE LEXINGTON, KY 40504** PROVIDER'S PLAN OF CORRECTION (X6) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH) DEFICIENCY MUST BE PRECEDED BY FULL PAEFIX PREFIX REGULATORY OR LSC (DENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY F 441 F 441 How will the facility monitor its performance Continued From page 17 to make sure solutions are sustained? revealed she had a bottle of sanitizer on top of the medication cart. The unit managers and house nurse supervisors will monitor two (2) staff members with 2. Observation of perineal care on 08/25/10 at 9:20 AM, revealed Certified Nursing Assistant Hand washing during resident care and use of (CNA) #5 wiped stool from the resident's anal Hand washing or hand sanitizer during area, removed the solled gloves, and opened the medication pass times and observe infection door to the hall. CNA #5 came back in the control precautions every shift for two (2) resident's room carrying bed linens. There was weeks, then every shift weekly for six (6) no evidence CNA #5 washed her hands after weeks, and then every shift monthly for three removing the solled gloves and prior to leaving (3) months. Unit Managers will report the room to obtain items from the linen cart. weekly to "Standards of Care" meetings any compliance concerns. Unit managers will address Interview with CNA #5 on 08/25/10 at 9:30 AM any findings and initiate any corrective actions revealed she removed her solled gloves and did at that time. Pharmacy will observe two (2) staff not wash her hands after performing perineal medication passes monthly for hand washing care. Further interview revealed she should have compliance for three (3) months and will washed her hands to prevent contamination. initiate any corrective action at that time, and will report to the monthly COI meeting. Interview on 08/26/10 at 9:30 AM with the Director Compliance will be reported by the of Nursing (DON)revealed staff should sanitize Director of Nursing during the monthly quality their hands between residents during medication assurance (COI) meeting. pass. Further interview revealed handwashing The infection control program monitoring should be done after the removal of gloves. will be reported by the DON in the mouthly Continued Interview, revealed she needed to CQI meetings. have a handwashing inservice. F 514 483.75(I)(1) RES F 514 Completion Date RECORDS-COMPLETE/ACCURATE/ACCESSIB 88#D 10/4/10 The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the

resident's assessments; the plan of care and

(X6) COMPLETION

DATE

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FAX NO. 859 276 2751 SEP-28-2010 TUE 12:28 PM LEXINGTON COUNTRY PLACE PRINTED: 09/09/2010 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X8) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 186160 08/26/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **700 MASON HEADLEY ROAD LEXINGTON COUNTRY PLACE LEXINGTON, KY 40504** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LISC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 514 F 514 F 614 Continued From page 18 services provided, the results of any This Plan of Correction constitutes our preadmission screening conducted by the State; facility's written allegation of compliance and progress notes. for the deficiencies cited. However, submission of this Plan of Correction in not an admission that a deficiency exists or that one was cited This REQUIREMENT is not met as evidenced correctly. This Plan of Correction is submitted to meet requirements established by the state Based on interview and record review it was and federal law. determined the facility failed to ensure clinical records were maintained on each resident in accordance with accepted professional standards It is the policy of Five Star Quality Care (Lexington Country Place) to provide or arrange and practices. services that meet professional standards of quality per state and federal regulations The findings include: (see attachment). Review of Resident #12's closed record revealed What corrective actions were taken for those diagnoses which included Dementia and Cerebrovascular Accident (CVA) with Hemiplegia. residents identified as having been affected Review of the Admission Minimum Data Setby the alleged deficient practice? (MDS) Assessment, dated 02/23/10 revealed the facility assessed the resident as having both short Resident #12 was identified as having been and long term memory loss, as requiring affected by the alleged deficient practice extensive to total assistance with Activities of of maintaining clinical records for each Daily Living, and as sustaining a fall within the last resident that are complete, accurately thirty (30) days. documented, readily accessible, and systematically organized; however Resident Review of an incident Report revealed the #12 is no longer a resident in our facility and resident sustained a fall on 02/11/10 at 10:00 AM this review was a closed record. and was found on the floor beside the bed on his/ her knees with no injuries noted. Further review of the Report revealed the Responsible Party was

Event (D: CHP111

notified on 02/11/10 at 2:00 PM. The section of

written in by Licensed Practical Nurse (LPN) #11.

Further review of the record revealed there was

no Nurse's Note written related to the fall on

02/11/10 at 10:00 AM.

FORM CM8-2567(02-99) Provious Varsions Obsolete

the Report which stated, "Was it necessary to notify the Physician ?" had N/A (not applicable) 2. What actions will be taken to identify other residents who may be affected by the alleged deficient practice?

All residents having an event that deems the completion of an incident report have the potential to be affected by the alleged deficient practice; therefore the facility will implement the corrective actions discussed in #3 below.

Medical Records audits five (5) active resident charts from each unit for compliance that the clinical records were complete, had accurate documentation, were readily accessible, and organized by 9/23/10. Any findings were addressed and any corrective actions were completed at that time.

PRINTED: 09/09/2010 **DEPARTMENT OF HEALTH AND HUMAN SERVICES** FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PAOVIDER/SUPPLIER/GLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C B, WING 185160 08/26/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **700 MASON HEADLEY ROAD LEXINGTON COUNTRY PLACE** LEXINGTON, KY 40504 PROVIDER'S PLAN OF CORRECTION **SUMMARY STATEMENT OF DEFICIENCIES** (X6) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY F 514 F 514 Continued From page 19 What measures will be put into place or what systemic changes will be made to ensure that Review of another Incident Report revealed the the alleged deficient practice will not reoccur? resident sustained a fall on 02/11/10 at 1:40 PM and was found lying on the floor beside the bed All Nursing staff have mandatory in-services scheduled for September 17th, 18th, and 23th with no injuries noted. Further review of the to be conducted by the Director of Nursing Report revealed the Responsible Party was notified on 02/11/10 at 2:10 PM. The section of related to the appropriate documentation the report which stated, "Was it necessary to required for a resident event and completion notify the Physician ?" had N/A (not applicable) of an incident report to maintain a complete. written in by Licensed Practical Nurse (LPN) #11. accurate, accessible, and organized resident Review of the Nurse's Notes dated 02/11/10 at 2:00 PM dld not Indicate if the Physician was All new hire nursing staff will be in-serviced on notified of the fall. the resident clinical record during the orientation Interview on 08/26/10 at 4:00 PM with LPN #11 All incident reports will be review by the revealed she no longer worked at the facility and nursing interdisciplinary team in the next she felt overwhelmed and dld not have enough day morning stand up meeting. The resident's training while working at the facility. Further record or chart will be brought to the stand up Interview revealed she knew to notify the meeting and will be compared to and reviewed Physician after a fall and had notified the Nurse with the incident report to ensure proper Practitioner who was on the unit verbally of the notification of family and physician, accurate falls on 02/11/10. She further stated, she should completion of the incident report, update to the have documented on the incident Report or on resident care plan, an appropriate resident the Nurse's Notes indicating the Nurse assessment was completed and a nursing Practitioner or Physician was notified. Further narrative documentation was completed. Interview revealed she assessed the resident Any findings will be addressed and any after the fails and completed the Incident Reports. She stated she thought she had documented her necessary corrective actions will be initiated assessment of the fall on the Nurse's Notes at that time. related to the fall on 02/11/10 at 10:00 AM. The MDS nurse and care plan team will audit the resident charts scheduled for that week's Attempts were made to reach the Nurse care plan meetings for maintaining a complete Practitioner: however she was unable to be and accurate clinical record. Any findings will

Interview on 08/26/10 at 3:30 PM with the Director of Health Services/ Corporate Administrator revealed she was in the facility daily during the time period of the resident's falls. She stated the

reached.

be addressed and any corrective actions will be

initiated at that time.

		& MEDICAID SERVICES	,		•		093 <u>8-0391</u>
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		- I' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		185160	B. WI	NG _			C B/2010
NAME OF P	ROVIDER OR SUPPLIER		•	S TR	EET ADDRESS, CITY, STATE, ZIP CODE	,	
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F 514	regardless f there was specified on the stated the nurses with an assefall. Interview on 08/26/of Nursing (DON) rethe facility in 02/10 falls. She further sometified of any fall, well as a Nurse's Na fall. She stated the	fy the Physician of any fall vas an injury and this should Incident Report. She further vere to complete a Nurse's sement of the resident after a 10 at 3:40 PM with the Direct evealed she did not work at at the time of the resident's tated the Physician should be and the Fall Incident Report a lote should be completed after the facility was unable to locate ated to the fall on 02/11/10 at	or	514	4. How will the facility monitor to make sure solutions are solutions and resident Completed daily in the scheduler solution plan. Medical records will audit to each unit monthly for complemaintaining complete and a records that are accessible a will report findings to the Expromptly if a correction is a monthly to the CQI team are audit as determined by the Compliance with this review by the Director of Nursing quality assurance (CQI) medical residuals.	e consist of the record review duled morning in the above wo (2) charts liance with a courate clinic and organized DON or MDS are deed and will conting to the moduring the medium of the moduring the medium of the moduring the medium of the	ne N N M M M M M M M M M M M
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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION NG 01	(X3) DATE S COMPLE	
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K 000	INITIAL COMMEN	TS	K 000			
	concluded on 08/20 to not meet the mir Code of the Federa The highest Scope Identified was a "D"			K 018		
K 018 88=D	Doors protecting or required enclosure hazardous areas a those constructed wood, or capable of minutes. Doors in required to resist the no impediment to the are provided with a the door closed. Dare permitted.	prohibited by CMS regulations	K 018	facility's written allega for the deficiencies cite of this Plan of Correcti that a deficiency exists correctly. This Plan of to meet requirements et and federal law. It is the policy of Five 3 (Lexington Country Pla Compliance with NFP) (2000 ed.) requirements (see attachment).	tion of compliance id. However, submission on in not an admission or that one was cited Correction is submitted stablished by the state Star Quality Care ace) to maintain A 101 Life Safety s/regulations.	1
		By	ECE SEP ?	O ZUIU So specific re	ve actions were taken for ified as having been as deficient practice? sidents were identified by the alleged deficient	as having
	This STANDARD 1	s not met as evidenced by:			will be taken to identify may be affected by the ice?	
,	determined the fac	lon and interview it was illy failed to ensure doors dor could resist the passage of D NFPA standards.		by the alleged	ave the potential to be deficient practice; ther il implement the correct 3 below.	efore
BORATOR	DIRECTOR'S OR PROVICE	HORUPPLIER REPRESENTATIVES SIGN	ATURE	TITLE (Q	(XXI) DATE

program participation. Evem ID: CHP121

Facility ID: 100527

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/08/2010

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/BUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING D1 B, WING 185160 08/25/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON COUNTRY PLACE LEXINGTON, KY 40504 (X4) ID PREFIX **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CHOSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) K 018 Continued From page 1 K 018 The findings include: What measures will be put into place or what systemic changes will be made to ensure that Observation on 08/25/2010 at 11:30 PM. the alleged deficient practice will not reoccur? revealed the resident's room door, in room number 116, was unable to resist the passage of The resident room door #116 was repaired amoke, due to a gap, of approximately 1/2 inch. by squaring the door and eliminating the gap. which was located at the top right section of the to correct the space located at the top right door. The observation was confirmed with the section of the door. The repair was completed Director of Maintenance, at that time. on August 25, 2010. All doors were inspected to assure proper Interview on 08/25/2010 at 11:30 PM, with the closure with no space/gaps present on Director of Maintenance, revealed he was August 25, 2010. unaware of the door having a gap which would allow smoke to enter the room in the event of a How will the facility monitor its performance fire. to make sure solutions are sustained? Reference: NFPA 101 (2000 edition) Ongoing compliance will be consist of all 19.3.6.3.1* Doors protecting corridor openings in door checked by maintenance staff monthly other than during Life Safety inspections and scheduled required enclosures of vertical openings, exits, or Fire Drills. hazardous Any findings will be addressed and any areas shall be substantial doors, such as those necessary corrective actions will be constructed of initiated at that time. 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and Compliance will be reported by the Maintenance Director or Administrator be constructed to resist the passage of smoke. during the monthly quality assurance Compliance (COI) meeting. with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the Completion Date door and 8/31/10 the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors... Exception No. 1: Doors to tollet rooms. bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING 01	(X3) DATE SU COMPLET	
		185160	B. WING		08/26	/2010
	ROVIDER OR SUPPLIER ON COUNTRY PLAC	E	8	TREET ADDRESS, CITY, STATE, ZIP CODE 700 MA9ON HEADLEY FIOAD LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	DATE DATE
K 018	contain flammable combustible materi Exception No. 2: In protected througho approved, supervisin accordance with 19.3.5.2, the door of 19.3.6.3.1 shall not	or als. smoke compartments ut by an ed automatic sprinkler system construction requirements of	K 01	8		
K 062 88=D	NFPA 101 LIFE SA Required automatk continuously maint condition and are in	FETY CODE STANDARD c sprinkler systems are alned in reliable operating aspected and tested 2.6, 4.6.12, NFPA 13, NFPA 26,	K 06	K 062 This Plan of Correction constitute facility's written allegation of corfor the deficiencies cited. However of this Plan of Correction in not a that a deficiency exists or that one correctly. This Plan of Correction to meet requirements established	opliance er, submission n admission was cited is submitted	
	This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility falled to ensure sprinkler heads were maintain according to NFPA standards. The findings include: Observation on 08/25/2010 at 1:36 PM, revealed one (1) sprinkler head in the kitchen area was found to be positioned to far into the ceiling to produce an effective spray pattern in the event of a fire. Further observation, of the conference room, revealed an escutcheon plate for one (1) sprinkler that had fallen down blocking the sprinkler head. The observations were confirmed with the Maintenance Director, at that time.			and federal law. It is the policy of Five Star Qualit (Lexington Country Place) to mai Compliance with NFPA 101 Life (2000 ed.) requirements/regulation (see attachment). 1. What corrective actions were	y Care ntein Safety ns.	, :
				residents identified as having by the alleged deficient practice. No specific residents were idented by the alleged.	; been affected dice? lentified as ha	l ving

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING 01		(X3) DATE SURVEY COMPLETED		
		185160	8. WING _		08/25/2010	
	ROVIDER OR SUPPLIER	E	70	EET AODRESS, CITY, STATE, ZIP CO OS MASON HEADLEY ROAD EXINGTON, KY 40504		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDEA'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETE EAPPROPRIATE DATE	DN
K 062	Interview on 08/25/2 Maintenance Direct sprinkler heads belice Reference: NFPA 2 2-2.1.1* Sprinklers floor level annually. Sprinklers foreign materials, paint, and physical in the proper orientation (a sidewail). Any sprinkler shall be re corroded, damaged loaded, or in the imp Exception No. 1:* S concealed spaces s above suspended of inspection. Exception No. 2: Spare inaccessible for safety considera operations shall be during each schedu 2-2,2* Pipe and Fitti fittings shall be inspected annually (fittings shall) be in good condition damage, leakage, corrosion, and misa shall not be subjected to externa resting on the pipe or hung from ti	2010 at 1:36 PM, revealed the for was unaware of the two (2) ng obstructed. 5 (1998 edition) shall be inspected from the shall be free of corrosion, damage and shall be installed e.g., upright, pendant, or placed that is painted, proper orientation. prinklers installed in such as eilings shall not require orinklers installed in areas that attors due to process inspected ited shutdown. Ings. Sprinkler pipe and in and free of mechanical dignment. Sprinkler piping at loads by materials either	K 062	in the conference room v proper position not to blo by maintenance on Aug	precised by the alleged openical to be affected practice; therefore and the corrective actions out into place or what a made to ensure that crice will not reoccur? ad located in the dot the accurate ffective spray pattern a August 30,2010. One (1) sprinkler located was repaired to the lock the sprinkler head ust 25, 2010. One to a August 25, 2010. One one consist of laker inspections by Maintenance staff ety inspections. It is performance to the laker inspections.	
ORM CM8-25	67(02-99) Previous Versions	Obsolete Event (D; OHP121	Fac	lity ID: 100527	Il continuation sheet Page 4 c	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2010 FORM A PPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER LEXINGTON COUNTRY PLACE				REET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLÉTION DATE	
	auch as above suspection. Exception No. 2: Pi inaccessible for safe considerations due inspected during each scheduled shu	pended ceilings shall not pe installed in areas that are ety to process operations shall be	K 06	6 K 076			
96= D	Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4			This Plan of Correction constituted facility's written allegation of for the deficiencies cited. How of this Plan of Correction in not that a deficiency exists or that correctly. This Plan of Correct to meet requirements establish and federal law. It is the policy of Five Star Quality (Lexington Country Place) to a Compliance with NFPA 101 L (2000 ed.) requirements/regulations.	compliance vever, submission ot an admission one was cited tion is submitted and by the state mainty Care maintain Life Safety		
	Based on observatil determined the fact wall fixtures inside of protected according. The findings include Observation on 08/2 that inside the oxygithe Station One Wild electrical wall fixture (2) feet high mounts.	e not met as evidenced by: on and interview, it was litty falled to ensure electrical oxygen storage rooms were to NFPA standards. 25/2010 at 11:38 AM, revealed en storage room located on ng, there were two (2) es located approximately two ed on the wall. Electrical wall atted a minimum of five (5)		What corrective actions we residents identified as having by the alleged deficient properties. No specific residents were been affected by the allegentation.	ving been affected ractice? e identified as having		

		1 AND HUMAN SERVICES	•			FORM	O9/08/2010 APPROVED			
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIET/CLIA IDENTIFICATION NUMBER:		A. BUIL	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED				
		186160	B. WING	G		08/2	6/2010			
NAME OF PROVIDER OR SUPPLIER LEXINGTON COUNTRY PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504						
(X4) ID PREFIX TAG	8UMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIDIENCY)		(XS) COMPLETION DATE			
K 076	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		Ko	K 076 2. What actions will be take residents who may be affideficient practice? All residents have the pot by the alleged deficient price the facility will implement discussed in #3 below. 3. What measures will be pure systemic changes will be the alleged deficient pract. The two (2) electrical wal repaired by raising both to wall height of five (5) feet the floor in the oxygen store on Station One (1). The resident pract on Station One (1). The resident pract on the facility to inspect. 4. How will the facility monitor make sure solutions are Ongoing compliance will monthly inspection of the room for safety checks by during Life Safety inspection initiated at that time. Compliance will be reported Maintenance Director or A during the monthly quality (CQI) meeting.		ntial to be affective; therefor the corrective into place or viade to ensure the minimum from the surface age room local was completed, 25, 2010. Storage rooms or its performants air was completed, 25, 2010, storage rooms or its performants air stained? e consist of exygen storage maintenance storage	eged ected re actions what that ccur? ce of ted leted			